

An 84-year-old woman with a history of sigmoid colon adenocarcinoma with urinary bladder invasion. Laparoscopic anterior resection and total cystectomy as well as ileal conduit with Wallace (conjoined) ureteroenteric anastomosis were performed on 4th, August, 1988. Colon cancer remained free of recurrence after the surgery.

An urosepsis episode occurred in October, 2015 and CT showed a 0.8cm stone formation over left upper third ureter. We were consulted for further intervention toward the ureter stone after sepsis subsided. We had performed flexible ureteroscopic lithotripsy via left percutaneous nephrolithotomy (PCN) on 21st, November, 2015. However, instead of located at left upper third ureter as shown in CT image, the stone was found impacted in right lower third ureter. Due to acute angle of the ureteroenteric anastomosis, we failed to approach to the stone. After the surgery, high fever was noted and later improved after another course of antibiotics. CT was arranged again and confirmed the 0.8cm radio-opaque ureter stone over right lower third ureter. On 2nd, December, 2015, radiologist had tried antegrade method via previous left PCN to remove the stone. Guiding wire, guiding catheter, balloon catheter and basket catheter were able to pass through the right ureter. However the ureteral stone couldn't be moved or retrieved despite several times of attempts. Then, the patient was positioned supine, in which another several attempts of stone retrieval were done via the ileal conduit. The ureteral stone remained still. Guidewires was left in bilateral ureter via ileal conduit by radiologist for guidance of future surgical intervention. Stone located in extraluminal location or diverticular pouch were suspected during the procedure. On 4th, December, 2015, we performed flexible cystoscopy via ileal conduit alongside guidewires toward bilateral ureters. The scope had reached up to bilateral upper third ureter, but still no stones were seen. We suspected the stone had expelled spontaneously. We arranged another CT and showed the stone was still at the distal site of right ureter. Right PCN was done on 9th, December, 2015. Radiologist performed antegrade stone removal with basket stone retractor and ureter balloon dilation via right PCN. The stone could not be approached. After discussion with the family and the patient, we performed flexible ureteroscopic lithotripsy again via right PCN on 12th, December, 2015, and we succeed stone fragmentation by Holmium LASER this time. The patient tolerated the surgery well. Follow-up KUB showed no residual stones. PCN was removed smoothly. This is a case of difficult ureter stone, which migrated from left ureter to right ureter in a patient with a history of ileal conduit with Wallace (conjoined)-typed ureteroenteric anastomosis.

Conclusion: Wallace-typed ureteroileal anastomosis can lead to stone migration from one ureter to the other. The anastomoses make ureter stone management much more difficult. Flexible antegrade ureterolithotripsy via PCN is a choice in management of ureter stones in these patients.

NDP061:

UNUSUAL COMPLICATION OF RETROPERITONEAL HEMATOMA AND HEMATOCELE OF SCROTUM AFTER ESWL

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Purpose: Extracorporeal shock wave lithotripsy (ESWL) has been widely used in medical practice since 1980s. Because of its noninvasive approach, it has become one of the main treatment options in patients with renal and/or ureteral calculi. Though it has been considered as a safe modality, there are still uncommon complications such as retroperitoneal hematoma and hematocele of scrotum happened, which may be severe and life-threatening. Only few cases have been reported according to our search, thus, we presented a case with retroperitoneal hematoma and hematocele after ESWL, and discussed the possible risk factor and treatment.

Case report: A 41-year-old Asian man without past history of systemic disease or coagulopathy, no daily usage of medication. He receive ESWL on 2015/10/05 for the right renal stone.

It was treated with MEDISPEC ECONOLITH 2000 lithotripter, 3000 shocks, were delivered to the stone, with rate 1 per second. He was then discharged from the recovery room. About 8 hours after ESWL, he presented to the emergency department due to severe right flank pain with gross hematuria, treated with pain control, intravenous fluid hydration, and then

discharged. He visited GU OPD 2 days later, at which the ecchymosis of the right flank region progressed, estimated 15 x 12cm in size. Also, the ecchymosis was noted over the penile skin and the bilateral scrotum. The drop of Hb was also noted, from 18.5 g/dL before ESWL to 11.3 g/dL. The CNCT of abdomen was done during the ER, results of one huge perirenal hematoma, right, and the hematoma extended downward along and within the right retroperitoneal space, all long to the right inguinal canal and scrotum. He was then admitted for further monitoring. During the hospital course, we kept conservative treatment, monitored his vital sign which no signs of hemorrhagic shock presented and the area of the ecchymosis did not progress. After days of treatment, he was then discharged under a stable condition.

During the OPD visiting 3 months later, the abdominal CT with contrast injection was done, revealed the size of the perirenal hematoma shrink and liquefied, and so as the size of the scrotal hematoma.

Conclusion: Extracorporeal shock wave lithotripsy (ESWL) has been widely used and considered as a safe modality in patients with renal and/or ureteral calculi. According to our search and review, there are only few cases presented with prominent hematoma and been reported. Few study indicated the incidence of perirenal hematoma range from 1% to 30%. The incidence of perirenal hematoma may be up to 30% if the CT scan been regularly used. The most common signs and symptoms include flank pain, hematuria, and skin bruising. The image modality may be indicated only if the signs and/or symptoms worsen or persisted. Also, initial blood transfusion may be needed if the patient presented with signs of hemorrhagic shock. According to our review, there are few risk factors associated with perirenal hematoma, including obesity, hypertension, old age, diabetes mellitus, coronary artery disease, coagulopathy or anticoagulation medication. Most of the perirenal hematoma can be treated conservatively, the initial blood transfusion may be needed. No surgical intervention been reported, but there was one case report mentioned the usage of percutaneous drainage for the symptomatic perirenal hematoma.

NDP062:

DIVERTICULUM STONE OUR EXPERIENCE

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Purpose: Diverticulum stone are rare type of renal stone which can be treated with several ways. ESWL, f-URS and PCNL. We are going to present our experience using PCNL for treatment of diverticulum stone during last decade.

Materials and Methods: We have collect case retrospectively from 2005 Jan to 2015 Dec. Those patients undergo PCNL either unilateral or bilateral. We would like to analyze the incidence of diverticulum stone in age, gender and body weight. In addition, we would like to present you the stone free rate, post operation hospital stay day and complications.

Results: Our data reveals that we have longer hospital stay than f-URS as showed in publish data. Our average hospital stay were 3 days as long as patient were discharged without tubing. The major complication were lower that current data.

Conclusion: Despite of instrument delay development in our hospital, we still have excellent result dealt with diverticulum stone. To develop new technique is importance but not missing those long standing technique. In experience surgeon, we could promise higher stone free rate and less cost that f-URS.

NDP063:

SUBCAPSULAR RENAL HEMATOMA AFTER URETEROSCOPIC PNEUMATIC LITHOTRIPSY FOR LOWER URETER STONE

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Purpose: Ureteroscopy is widely used in treating upper urinary tract pathologies. Ureteroscopic lithotripsy (URSL) has been a common